CERTIFIED MAIL RETURN RECEIPT REQUESTED NO. P505281225

Amy Esposito
80 Sharon Road
Stratford, CT 06497

STATE OF CONNECTICUT
BOARD OF EXAMINERS FOR NURSING

State of Connecticut
Department of Public Health
vs.
Amy Esposito, RN
Registered Nurse License No. E55481
Respondent.

CASE PETITION NO. 960614-010-043

MEMORANDUM OF DECISION

PROCEDURAL BACKGROUND

The Board of Examiners for Nursing (hereinafter the "Board") was presented by the Department of Public Health (hereinafter the "Department") with a Statement of Charges and Motion for Summary Suspension dated April 22, 1997 (Department Exhibit 1). The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut by Amy Esposito (hereinafter the "Respondent") which would subject the Respondent's Registered Nurse license to disciplinary action pursuant to the General Statutes of Connecticut.

Based on the allegations in the Statement of Charges and accompanying affidavits and reports, the Board found that the continued nursing practice of the Respondent presented a clear and immediate danger to public health and safety. On April 30, 1997 the Board ordered, pursuant to its authority under §19a-17(c) of the General Statutes of Connecticut, that the Registered Nurse license of the Respondent be summarily suspended pending a final determination by the Board of the allegations contained in the Statement of Charges (Department Exhibit 1).

The Board issued a Notice of Hearing dated April 30, 1997, scheduling a hearing for May 21, 1997 (Department Exhibit 1).

The Respondent was provided notice of the hearing and charges against her. Department Exhibit 1 indicates that the Statement of Charges, Summary Suspension Order and Notice of Hearing were delivered by certified mail to the Respondent and the Respondent's attorney.

The hearing took place on May 21, 1997, in Conference Room AB, 470 Capitol Avenue, Hartford, Connecticut, and on July 9, 1997 in Room 2-A, Legislative Office Building, Capitol Avenue, Hartford, Connecticut. A hearing date scheduled for August 13, 1997 was continued at the Respondent's request. The hearing resumed on September 3, 1997 and concluded on September 10, 1997 in Room 2-A, Legislative Office Building, Capitol Avenue, Hartford, Connecticut. The Respondent was present on all hearing dates and was represented by counsel.

The Respondent submitted a written answer to the Statement of Charges. (Department Exhibit 1, p. 5)

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record, the law, and the Board's specialized professional knowledge in evaluating the evidence.

FACTS

Based on the testimony given and the exhibits offered into evidence, the Board makes the following Findings of Fact:

1. Amy Esposito, hereinafter referred to as the Respondent, was issued Registered Nurse License Number E55481 on April 1, 1993. The Respondent was the holder of said license at all times referenced in the Statement of Charges. (Department Exhibit 1-A1) (Answer: Department Exhibit 1)

2. Between approximately April 1995 and May 1996, the Respondent was employed as a registered nurse by Olsten Kimberly Quality Care, a home health care agency located in Hamden, Connecticut. The Respondent was initially employed on a per diem basis. The Respondent

began full time employment on or about January 1996. The Respondent was responsible for providing in-home nursing care to patients who were clients of Olsten Kimberly Quality Care. The Respondent was terminated from Olsten Kimberly Quality Care on or about May 16, 1996. (Department Exhibits 1-B6; 11-p. 2; 15-p.5) (Hearing Transcript, May 21, 1997, p. 166, 181) (Hearing Transcript, July 9, 1997, pp. 83-84)

3. It was the policy of Olsten Kimberly Quality Care that at the time of a home visit to a client, an employee time slip would be completed confirming that a visit to the client was made. It was required that the client or a designated individual sign the time slip at the time of the visit by Olsten Kimberly Quality Care personnel. (Hearing Transcript, July 9, 1997, pp. 90-91, 102-103)

4. On or about January 2, 1996, Janet Burwell became a client of Olsten Kimberly Quality Care. Physician orders for patient Burwell required skilled nursing visits two to three times weekly which were to include an assessment of the patient's diabetic status. Effective March 2, 1996 the physician orders were modified to decrease skilled nursing visits to one to two times weekly. (Department Exhibits 2, 9)

5. On January 10, 15, 17, and 30, 1996; February 1, 5, 8, 14, 20, and 22, 1996; and March 4, 12, 20 and 25, 1996 the Respondent completed nursing notes documenting that she provided nursing care to patient Janet Burwell on said dates. The nursing notes include documentation of nursing assessments, interventions, observations and responses to interventions. (Department Exhibit 9)

6. Of the dates cited in Fact 5, the respondent only visited patient Burwell on January 15, 1996. Of the corresponding employee time slips for the dates cited in Fact 5, patient Burwell only signed the time slip for January 15, 1996. (Department Exhibit 1-C4) (Hearing Transcript, May 21, 1997, pp. 144-146)

7. On or about April 8, 1996, patient Burwell reported to Joanne Apuzzo, RN of Olsten Kimberly Quality Care that she had not been seen by a nurse for at least a month. At this time patient Burwell's diabetic condition was found to be out of control. Patient Burwell's physician was

notified and skilled nursing visits were increased for the purpose of monitoring the patient's blood sugar. (Department Exhibits 2, pp. 2-3; 17) (Respondent's Exhibit A, p.3) (Hearing Transcript, July 9. 1997, pp. 109-111, 122-124)

8. On or about February 23, 1996, Edward Carr became a client of Olsten Kimberly Quality Care. Patient Carr's diagnosis included gastrointestinal bleeding, glaucoma, seizure disorder, and non-insulin dependent diabetes mellitus. Patient Carr required assistance with all activities of daily living, inclusive of feeding. Physician orders for patient Carr required at least two to four skilled nursing visits weekly. Patient Carr also had orders for various medications, however, said orders did not include Insulin. (Department Exhibits 1, 2, 10) (Hearing Transcript, July 9, 1997, p. 8)

9. Patient Carr was not able to sign his name. Therefore, the patient's wife and daughter were authorized, pursuant to a "General Consents and Notices" form, to use their own signatures to sign employee time slips confirming that a visit was made to the patient by Olsten Kimberly Quality Care personnel. (Department Exhibits 1-B2, 1-C3, 2, 10) (Hearing Transcript, May 21, 1997, pp. 154-156, 158-159) (Hearing Transcript, July 9. 1997, pp. 11, 102-104)

10. On March 12, 1996 and March 29, 1996 the Respondent completed nursing notes documenting that she provided nursing care to patient Edward Carr on said dates. The nursing notes include documentation of nursing assessments, interventions, observations and responses to interventions. Corresponding employee time slips for these visits contain the signature "Edward Carr." (Department Exhibit 10)

11. The nursing notes for patient Carr dated March 29, 1996, indicate that the patient had normal blood sugar. The notes further indicate, despite being a total care client as well as not having an order for Insulin nor requiring Insulin, the patient administered Insulin to himself. (Department Exhibit 10) (Hearing Transcript, July 9, 1997, pp. 8-9)

12. Patient Carr's wife, who was at home on March 29, 1996, reported that the Respondent did not make a nursing visit to the patient on said date. (Department Exhibits 1-B2; 1-B4; 11; 15, p.5)

13. On or about February 8, 1996, Jemal Streater became a client of Olsten Kimberly Quality Care. Physician orders for patient Streater required at least one to two skilled nursing visits weekly. Patient Streater also had orders for twice daily dressing changes of a decubitus ulcer. (Department Exhibits 2, 13) (Hearing Transcript, July 9, 1997, pp. 10-11)

14. On February 10 and 17, 1996; March 11, 12, 13, 14, 15, 18, 19, 20, 21, 26, 27, and 29, 1996 and April 1, 1996 the Respondent completed nursing notes documenting that she provided nursing care to patient Jemal Streater on said dates. The nursing notes include documentation of nursing assessments, interventions, observations and responses to interventions. (Department Exhibit 13)

15. Of the corresponding employee time slips for the dates cited in Fact 14, patient Streater only signed the time slips for March 11, 12, 19 and 29, 1996, and April 1, 1996. (Department Exhibit 1-C2)

16. Patient Streater reported to Betty Wlazlo, RN that the Respondent failed to make scheduled home care visits to him on March 26 and 27, 1996 and April 2, 1996. (Department Exhibits 1-B, 1-C6-7; 2) (Respondent's Exhibit A) (Hearing Transcript, July 9, 1997, pp. 128-137, 144-145)

17. Jose Santiago was a client of Olsten Kimberly Quality Care. Patient Santiago required nursing care for a decubitus ulcer and for pouring of his medications. Patient Santiago also had orders for twice daily dressing changes of the decubitus ulcer. (Hearing Transcript, May 21, 1997, p. 202) (Hearing Transcript, July 9, 1997, pp. 130, 154)

18. On March 18, 20, 21, 22, 26, 27, and 29, 1996 and April 1 and 2, 1996 the Respondent completed nursing notes documenting that she provided nursing care to patient Jose Santiago on said dates. The nursing notes include documentation of nursing assessments, interventions, observations and responses to interventions. (Department Exhibit 14)

19. Patient Santiago reported to Betty Wlazlo, RN that the Respondent failed to make scheduled home care visits to him on March 26 and 27, 1996 and April 2, 1996. (Department Exhibits 1-B, 1-C6-7; 2) (Respondent's Exhibit A) (Hearing Transcript, July 9, 1997, pp. 128-137, 144-145)

20. Wound size measurements documented by the Respondent for patients Santiago and Streater fluctuated dramatically and were not consistent with those documented by other nursing personnel that cared for these patients. (Department Exhibit 1-B5) (Hearing Transcript, July 9, 1997, pp. 98-99)

21. Between approximately June 1996 and December 1996, the Respondent was employed as a registered nurse by Optimum Health Care (formerly Health Resources Home Care, Inc.), a home health care agency located in Cromwell, Connecticut. (Hearing Transcript, May 21, 1997, pp. 52, 117-118)

22. On June 3, 1996 the Respondent completed an employment application for Health Resources, Inc., Cromwell, Connecticut. On said application the Respondent answered "no" to the question "Have you ever been dismissed from prior employment?" On said application the Respondent listed Olsten Kimberly Quality Care as a previous employer but falsely indicated the reason for leaving as "was going to relocate to Florida" and falsely indicated that said employment ended in January 1996. (Department Exhibit 7)

23. On July 30, 1996 the Respondent completed an employment application for Health Resources, Home Care Inc., Cromwell, Connecticut. On said application the Respondent answered "no" to the question "Have you ever been dismissed from prior employment?" On said application the Respondent listed Olsten Kimberly Quality Care as a previous employer but falsely indicated the reason for leaving as "no full time" and falsely indicated that said employment ended in January 1996. (Department Exhibit 6)

24. On or about September 9, 1996, Kim Figlar became a client of Optimum Health Care (Health Resources Home Care). Physician orders for patient Figlar required skilled nursing visits once

every twenty-eight (28) days. Effective October 21, 1996 the physician orders were modified to increase skilled nursing visits to one to two times weekly. The nursing visits were to include the monitoring and assessment of the patient's medication regime.' (Department Exhibits 1-D1, 4)

25. On September 9 and 25, 1996; October 21, 24 and 29, 1996; and November 8, 20, and 27, 1996 the Respondent completed nursing notes documenting that she provided nursing care to patient Kim Figlar on said dates. The nursing notes include documentation of vital signs, nursing assessments, interventions, responses to interventions, and goals. (Department Exhibits 1-D1, 4)

26. Of the dates cited in Fact 25, the respondent only visited patient Figlar on September 9, 1996 and October 21, 1996. (Department Exhibits 1-D) (Hearing Transcript, May 21, 1997, pp. 89-90) (Hearing Transcript, July 9, 1997, pp. 57-58, 75)

DISCUSSION AND CONCLUSIONS

In consideration of the above Findings of Fact, the following conclusions are rendered:

Amy Esposito held a valid Registered Nurse license in the State of Connecticut at all times referenced in the Statement of Charges.

The Summary Suspension Order, Notice of Hearing, and Statement of Charges sufficiently provided legal notice as mandated by the General Statutes of Connecticut §4-177, §4-182 and §19a-17. The hearing was held in accordance with Chapters 54 and 368a of the General Statutes of Connecticut as well as §19-2a-1 through §19-2a-30 of the Regulations of Connecticut State Agencies.

The Notice of Hearing, Statement of Charges and the hearing process provided the Respondent with the opportunity to demonstrate compliance with all lawful requirements for the retention of her license as required by the General Statutes of Connecticut §4-182(c).

The Department bears the burden of proof by a preponderance of the evidence in this matter.

The FIRST COUNT PARAGRAPH 2 of the Statement of Charges alleges that between approximately December 1995 and April 1996, while employed as a registered nurse by Olsten Kimberly Quality Care, Hamden, Connecticut, the Respondent:

"a. failed to make scheduled and/or ordered home visits;
b. failed to completely, properly and/or accurately document medical records;
c. forged patient's signatures and/or the signature of other designated persons on time slips;
d. falsified nursing notes regarding home visits; and/or,
e. failed to assure that medication was administered to patients as ordered by the physician."

The Respondent denies these charges. (Answer: Department Exhibit 1, p. 5)

The Board finds that there exists ample and credible evidence that the Respondent, while working as a registered nurse for Olsten Kimberly Quality Care, failed to make scheduled and/or ordered skilled nursing visits to patients Burwell, Carr, Streater and Santiago. The Board further finds that the Respondent purposefully falsified the medical records of said patients by generating nursing notes for home care visits which were not performed.

It is proven that the Respondent did not make scheduled and/or ordered homecare visits to patients. The Board therefore concludes that said patients did not receive the required medical care and attention which was ordered by their physician and for which the nursing visits were intended. In doing so the Respondent placed the patients' well-being in jeopardy. The Board further concludes that the Respondent's willful falsification of the patients' medical records created the potential for the patients to receive inappropriate and/or detrimental care.

The Board does not consider the Respondent's testimony in relation to these charges to be credible.

The General Statutes of Connecticut §20-99(b) prohibits conduct which fails to conform to the accepted standards of the nursing profession, which includes "...(2) illegal conduct, incompetence or negligence in

performing usual nursing functions...(6) fraud or material deception in the course of professional services or activities...."

Based on its findings, the Board concludes that the Respondent's conduct as alleged in the First Count Paragraphs 2a, 2b, 2d, and 2e of the Statement of Charges is proven by a preponderance of the evidence. The Board further concludes that said conduct fails to conform to the accepted standards of the nursing profession, and constitutes violations of the General Statutes of Connecticut §20-99(b)(2) and (6). Therefore, the Respondent is subject to disciplinary action pursuant to §19a-17 of the General Statutes of Connecticut.

With regard to the Paragraph 2c of the First Count, the Board concludes that insufficient evidence was presented to prove this charge. Therefore, the First Count Paragraph 2c is dismissed.

The SECOND COUNT PARAGRAPH 5 of the Statement of Charges alleges that between approximately June 1996 and December 1996, while employed as a registered nurse at Optimum Health Care, Cromwell, Connecticut, the Respondent:

"a. failed to make scheduled and/or ordered home visits;
b. failed to completely, properly and/or accurately document medical records;
c. falsified nursing notes regarding home visits; and/or,
d. failed to assure that medication was administered to patients as ordered by the physician."

The Respondent denies these charges. (Answer: Department Exhibit 1, p. 5)

The Board finds that there exists ample and credible evidence that the Respondent, while working as a registered nurse for Optimum Health Care, failed to make scheduled and/or ordered skilled nursing visits to patient Figlar. The Board further finds that the Respondent purposefully falsified the medical records of said patient by generating nursing notes for home care visits which were not performed.

It is proven that the Respondent did not make scheduled and/or ordered homecare visits to patient Figlar. The Board therefore concludes that said patient did not receive the required medical care and attention which was ordered by her physician and for which the nursing visits were intended. In doing so the Respondent placed the patient's well-being in jeopardy. The Board further concludes that the Respondent's willful falsification of the patient's medical records created the potential for the patient to receive inappropriate and/or detrimental care.

The Board does not consider the Respondent's testimony in relation to these charges to be credible.

The General Statutes of Connecticut §20-99(b) prohibits conduct which fails to conform to the accepted standards of the nursing profession, which includes "...(2) illegal conduct, incompetence or negligence in performing usual nursing functions...(6) fraud or material deception in the course of professional services or activities...."

Based on its findings, the Board concludes that the Respondent's conduct as alleged in the Second Count Paragraph 5 of the Statement of Charges is proven by a preponderance of the evidence. The Board further concludes that said conduct fails to conform to the accepted standards of the nursing profession, and constitutes violations of the General Statutes of Connecticut §20-99(b)(2) and (6). Therefore, the Respondent is subject to disciplinary action pursuant to §19a-17 of the General Statutes of Connecticut.

ORDER

Pursuant to its authority under §19a-17 and §20-99 of the General Statutes of Connecticut, the Board of Examiners for Nursing hereby orders the following:

1. That for the First Count Paragraphs 2a, 2b, 2d, 2e and the Second Count Paragraph 5 of the Statement of Charges, the Respondent's registered nurse license, No. E55481, is revoked effective the date this Memorandum of Decision is signed by the Board of Examiners for Nursing.

The Board of Examiners for Nursing finds the misconduct regarding the First Count and the Second Count is severable and each specific offense warrants the disciplinary action imposed.

The Board of Examiners for Nursing hereby informs the Respondent, Amy Esposito, and the Department of Public Health of the State of Connecticut of this decision.

Dated at Hartford, Connecticut this 18th day of March 1998.

BOARD OF EXAMINERS FOR NURSING

By _____

esposito.doc

CERTIFICATION

I hereby certify that, pursuant to Connecticut General Statutes §4-180(c), a copy of the foregoing Memorandum of Decision was sent this 18th day of March 1998, by certified mail, return receipt requested to:

Amy Esposito
80 Sharon Road
Stratford, CT 06497

Certified Mail Return Receipt Requested NO. P505281225

and

E. Allen Vitello, Esq.
115 Main Street
South Meriden, CT 06451

Certified Mail Return Receipt Requested NO. P505281226

Jeffrey A. Kardys
Special Investigator
Division of Health Systems Regulation

certmod.doc